		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039370

Facility Name: Marigold Estates

Address: 3240 Barney Avenue (Number) Pekin (City) 61554 (Zip Code)

County: Tazewell

Telephone Number: 309-347-6514 **Fax #** ( )

HFS ID Number: 37-1281054

Date of Initial License for Current Owners: 10/26/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: W.R. Moss, CPA **Telephone Number:** 217-875-2655

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/04 to 09/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Daniel P. Caulkins
(Title) President

Paid Preparer
(Signed) See Attached Compilation Report (Date)
(Print Name and Title) William R. Moss, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Rd, Decatur, IL 62526
(Telephone) 217-875-2655 Fax # 217-875-1660

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,784			5,784	13
14	TOTALS	5,784			5,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.04%

D. How many bed-hold days during this year were paid by the Department?
56 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 9/30/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	24,010	1,810	1,629	27,449		27,449		27,449			1
2	Food Purchase		34,220		34,220	(3,650)	30,570		30,570			2
3	Housekeeping	16,640	7,185	1,488	25,313		25,313		25,313			3
4	Laundry	10,639	2,393		13,032		13,032		13,032			4
5	Heat and Other Utilities			9,823	9,823		9,823		9,823			5
6	Maintenance		2,995	9,863	12,858		12,858		12,858			6
7	Other (specify):*											7
8	**TOTAL General Services**	51,289	48,603	22,803	122,695	(3,650)	119,045		119,045			8
	B. Health Care and Programs											
9	Medical Director			800	800		800		800			9
10	Nursing and Medical Records	114,460	938	10,274	125,672		125,672		125,672			10
10a	Therapy			443	443		443		443			10a
11	Activities	23,531	14,197		37,728		37,728		37,728			11
12	Social Services	29,486		819	30,305		30,305		30,305			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	167,477	15,135	12,336	194,948		194,948		194,948			16
	C. General Administration											
17	Administrative	84,069			84,069		84,069		84,069			17
18	Directors Fees											18
19	Professional Services			6,997	6,997		6,997		6,997			19
20	Dues, Fees, Subscriptions & Promotions			3,164	3,164		3,164	(1,693)	1,471			20
21	Clerical & General Office Expenses		3,913	4,530	8,443		8,443		8,443			21
22	Employee Benefits & Payroll Taxes			47,200	47,200	3,650	50,850		50,850			22
23	Inservice Training & Education			606	606		606		606			23
24	Travel and Seminar			266	266		266	(266)				24
25	Other Admin. Staff Transportation			10,103	10,103	(10,046)	57		57			25
26	Insurance-Prop.Liab.Malpractice			19,291	19,291		19,291		19,291			26
27	Other (specify):* **Penalties**			5,000	5,000		5,000	(5,000)				27
28	**TOTAL General Administration**	84,069	3,913	97,157	185,139	(6,396)	178,743	(6,959)	171,784			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	302,835	67,651	132,296	502,782	(10,046)	492,736	(6,959)	485,777			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marigold Estates #0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,023	8,023		8,023	13,332	21,355			30
31	Amortization of Pre-Op. & Org.			16,593	16,593		16,593	(16,593)				31
32	Interest			8,653	8,653		8,653	9,927	18,580			32
33	Real Estate Taxes			7,960	7,960		7,960		7,960			33
34	Rent-Facility & Grounds			31,446	31,446		31,446	(29,496)	1,950			34
35	Rent-Equipment & Vehicles			9,800	9,800		9,800		9,800			35
36	Other (specify):*											36
37	TOTAL Ownership			82,475	82,475		82,475	(22,830)	59,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					10,046	10,046		10,046			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,266	40,266		40,266		40,266			42
43	Other (specify):* State income tax			772	772		772	(772)				43
44	TOTAL Special Cost Centers			41,038	41,038	10,046	51,084	(772)	50,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	302,835	67,651	255,809	626,295		626,295	(30,561)	595,734			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(266)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,000)	27		18
19	Entertainment	(870)	20		19
20	Contributions	(823)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(772)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,956)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,687)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,874)	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (11,874)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,561)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 10,046	25	38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 10,046		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Marigold Estates

ID# **0039370**

Report Period Beginning: **10/01/04**

Ending: **09/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill Amortizsation	$ (16,593)	31	1
2	Depreciation - Central Office	2,943	30	2
3	Depreciation--Adjustment	2,694	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,956)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Marigold Estates **#** 0039370 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,693)	0	0	0	0	0	0	0	0	0	0	(1,693)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(266)	0	0	0	0	0	0	0	0	0	0	(266)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	27
28	**TOTAL General Administration**	(6,959)	0	0	0	0	0	0	0	0	0	0	(6,959)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,959)	0	0	0	0	0	0	0	0	0	0	(6,959)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Marigold Estates** **#** **0039370** **Report Period Beginning:** **10/01/04** **Ending:** **09/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	5,637	7,695	0	0	0	0	0	0	0	0	0	13,332	30
31	Amortization of Pre-Op. & Org.	(16,593)	0	0	0	0	0	0	0	0	0	0	(16,593)	31
32	Interest	0	9,927	0	0	0	0	0	0	0	0	0	9,927	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(29,496)	0	0	0	0	0	0	0	0	0	(29,496)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,956)	(11,874)	0	0	0	0	0	0	0	0	0	(22,830)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(772)	0	0	0	0	0	0	0	0	0	0	(772)	43
44	TOTAL Special Cost Centers	(772)	0	0	0	0	0	0	0	0	0	0	(772)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(18,687)	(11,874)	0	0	0	0	0	0	0	0	0	(30,561)	45

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard Grader	50	Patterson House	Sullivan	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Carlinville Estates	Carlinville			
		Emerald Estates	Canton			
		Marigold Estates	Pekin			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Two-Can, Inc.		$ 7,695	$ 7,695	1
2	V	32	Interest		Two-Can, Inc.		9,927	9,927	2
3	V	34	Rent	29,496				(29,496)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 29,496			$ 17,622	$ * (11,874)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Richard L. Grader	President	Administration	50.00	See	10	25.00	Wages	$ 32,253	17.1	1
2	Daniel P. Caulkins	Vice President	Administration	50.00	Attached	10	25.00	Wages	32,253	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 64,506		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Central Office-Patterson House
Street Address: 120 East Cerro Gordo
City / State / Zip Code: Decatur, IL 62525
Phone Number: (217-422-6510
Fax Number: (217-422-6819

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Attached Schedule				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Regions Bank & Trust		X	Mortgage	$1,865.00	11/30/03	$ 152,796	$ 126,042	11/30/08	4.2500	$ 7,562	1
2	Regions Bank & Trust		X	Mortgage	$2,468.00	11/30/03	199,919	164,913	11/30/08	4.2500	9,927	2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank & Trust		X	Working Capital		12/01/03					1,091	6
7												7
8												8
9	TOTAL Facility Related				$4,333.00		$ 352,715	$ 290,955			$ 18,580	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 352,715	$ 290,955			$ 18,580	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Marigold Estates # 0039370 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 4,322	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 7,960	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,638	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,322	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,960	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	10,004	8
	2001	10,203	9
	2002	10,384	10
	2003	7,414	11
	2004	7,960	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Estates COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0039370

CONTACT PERSON REGARDING THIS REPORT W.R. Moss, CPA

TELEPHONE 217-875-2655 FAX #: 217-875-1660

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-07-107-009	Sec 7, T24N R4W Pt of E 1/2 NW 1/	$ 7,960.16	$ 7,960.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,960.16	$ 7,960.16

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services: ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,356 B. General Construction Type: Exterior Brick- Vinyl Side Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	50,625	1993	$ 26,000	1
2					2
3	TOTALS	50,625		$ 26,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1989	$ 295,000	$	40	$ 7,375	$ 7,375	$ 87,271	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing & Electrical			9/1/1994	1,783		10			1,783	9
10	Remodeling			9/1/1996	5,000		5			5,000	10
11	Carpet, Tile, Flooring			9/1/1996	5,099		5			5,099	11
12	Lumber & Hardware to Repair Bathroom			9/25/1998	2,940		5			2,940	12
13	Excavation & Sewer work			4/1/1998	850		5			850	13
14	Plumbing work			4/1/1998	899		5			899	14
15	Interior repair, bathroom - Electrical & Lumber			4/1/1998	3,735		5			3,735	15
16	Lumber - Repair bathroom			1/31/1999	1,600		5			1,600	16
17	Painting & wallpaper			7/23/2002	5,534		5	1,107	1,107	3,597	17
18	Furnace & Air Conditioner			2/4/2004	9,782		5	1,956	1,956	3,261	18
19	Carpet			7/31/2004	3,797		5	759	759	886	19
20	Carpet			2/15/2005	603		5	80	80	80	20
21	Carpet			3/31/2005	3,445		5	344	344	344	21
22	Remodeling			3/31/2005	4,248		5	425	425	425	22
23	Carpet			3/31/2005	2,110		5	211	211	211	23
24	New Driveway			5/31/2005	23,276		15	517	517	517	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 369,701	$		$ 12,774	$ 12,774	$ 118,498	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 44,439	$ 4,968	$ 2,425	$ (2,543)		$ 43,199	71
72	Current Year Purchases	24,852	3,055	3,611	556		3,611	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 69,291	$ 8,023	$ 6,036	$ (1,987)		$ 46,810	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administration	2003 Cadillac Escalade	11/20/2003	$ 12,724	$	$ 2,545	$ 2,545	5	$ 4,666	76
77										77
78										78
79										79
80	TOTALS			$ 12,724	$	$ 2,545	$ 2,545		$ 4,666	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 477,716	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,023	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,355	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,332	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 169,974	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Central Office - See Attached Schedule
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached		$	$ 9,800	17
18					18
19					19
20					20
21	TOTAL		$	$ 9,800	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service	Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 100	$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	137,939	530,793	3
4	Supply Inventory (priced at cost)	612	4,541	4
5	Short-Term Investments			5
6	Prepaid Insurance		33,139	6
7	Other Prepaid Expenses	1,104	4,947	7
8	Accounts Receivable (owners or related parties)		150,884	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 139,755	$ 724,804	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		257,586	14
15	Leasehold Improvements, at Historical Cost	56,052	125,948	15
16	Equipment, at Historical Cost	73,489	332,804	16
17	Accumulated Depreciation (book methods)	(56,407)	(362,804)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(196,351)	(599,283)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	248,894	746,683	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 125,677	$ 531,716	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 265,432	$ 1,256,520	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 97,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10		28
29	Short-Term Notes Payable		159,000	29
30	Accrued Salaries Payable		42,175	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,513	39,193	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,036	25,611	32
33	Accrued Interest Payable	815	2,444	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Sundry		57,000	36
37	Interco account	103,708		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 123,082	$ 423,037	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		30,089	39
40	Mortgage Payable	126,042	526,294	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 126,042	$ 556,383	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 249,124	$ 979,420	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,308	$ 277,100	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 265,432	$ 1,256,520	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Marigold Estates # 0039370 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 98,026	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 98,026	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,523)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(51,195)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (81,718)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 16,308	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 584,179	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 584,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	335	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 335	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,212	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,212	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Reimburse resident's travel	10,046	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,046	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 595,772	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	122,695	31
32	Health Care	194,948	32
33	General Administration	185,139	33
	B. Capital Expense		
34	Ownership	82,475	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,266	36
	D. Other Expenses (specify):		
37	State income tax	772	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 626,295	40
41	**Income before Income Taxes (line 30 minus line 40)****	(30,523)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (30,523)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

Tax return is cash basis calendar year

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	12,980	13,065	114,460	8.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,125	23,531	11.07	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	29,486	14.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,080	2,080	18,720	9.00	14
15	Cook Helpers/Assistants	604	604	5,290	8.76	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,937	1,957	16,640	8.50	18
19	Laundry	1,221	1,251	10,639	8.50	19
20	Administrator	500	520	13,692	26.33	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	64,506	62.03	22
23	Office Manager					23
24	Clerical	500	520	5,871	11.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,982	25,242	$ 302,835 *	$ 12.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	35	$ 1,629	1.3	35
36	Medical Director	8	800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	110	3,323	10.3	38
39	Pharmacist Consultant	8	400	10.3	39
40	Physical Therapy Consultant	7	331	10a.3	40
41	Occupational Therapy Consultant	4	188	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	125	10.3	43
44	Activity Consultant				44
45	Social Service Consultant	20	819	12.3	45
46	Other(specify) Psychologist	35	1,799	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	$ 9,414		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Danneberger	Offc Assistant	0	$ 5,871
Richard L. Grader	Administrative	50	32,253
Daniel P. Caulkins	Administrative	50	32,253
Lori Dillman	Administrator	0	13,692
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,069

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Chamblin, Moss & Moore	CPA	$ 6,084
May, Cocagne & King, P.C.	CPA	500
Samuels Miller, etc	Attorney	413
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,519
Unemployment Compensation Insurance	1,771
FICA Taxes	21,675
Employee Health Insurance	14,506
Employee Meals	3,650
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	45
Sundry	684
TOTAL (agree to Schedule V, line 22, col.8)	$ 50,850

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 100
Advertising: Employee Recruitment	537
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues, subs, sundry	834
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,471

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marigold Estates # 0039370 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,266**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,650** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **10,046**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Patterson House, Inc.
Carlinville Estates
Emerald Estates
Marigold Estates

Allocation of Central Office Costs
Year Ended September 30, 2005

The group consists of four DD homes - All with 16 beds.

All costs of the central office and common costs are allocated 25% to each facility

Costs for this schedule were determined by finding the sum of those costs
in the general ledger which were evenly allocated among the four facilities

	Total Expense	Carlinville 25%	Emerald 25%	Marigold 25%	Patterson House 25%	Line Ref
Professional fees	27,638	6,910	6,910	6,910	6,910	19
Donations	1,325	331	331	331	331	20
Postage	1,756	439	439	439	439	21
Telephone	9,570	2,393	2,393	2,393	2,393	21
Utilities - Central Office	902	225	225	225	225	5
Group Insurance	38,602	9,651	9,651	9,651	9,651	22
Workers Comp Insurance	27,097	6,774	6,774	6,774	6,774	22
General Insurance	60,248	15,062	15,062	15,062	15,062	26
Business Meals	2,048	512	512	512	512	20
Depreciation	11,774	2,944	2,944	2,944	2,944	30
Interest expense	34,483	8,621	8,621	8,621	8,621	32
Lease Expense - Central Offic	7,800	1,950	1,950	1,950	1,950	34
Rent - Vehicles	9,963	2,491	2,491	2,491	2,491	35
State Income Tax Expense	3,088	772	772	772	772	43
	236,295.73	59,073.93	59,073.93	59,073.93	59,073.93	

MARIGOLD ESTATES

PAGE 3, LINE 25

September 30, 2005

Fuel and repairs for the facility vehicles	8,015
Reimbursement of employee, care-related local travel	2,088
	10,103
Less: Allocation to page 4, line 38	(10,046)
	57

CARLINVILLE ESTATES
EMERALD ESTATES
MARIGOLD ESTATES

PAGE 6, PART VII, B

The facility building and land are owned by a related corporation.
Two-Can, Inc. has the same shareholders as Patterson House, Inc.

Two-Can, Inc. has the following basis in the building and land:

	Land	Building
Carlinville Estates	18,000	252,000
Emerald Estates	21,000	262,000
Marigold Estates	26,000	295,000

Interest accrued by Two-Can, Inc. on its mortgage was as follows:

Regions Bank	4.25%	29,781

The interest is allocated as follows:

Carlinville	9,927
Emerald	9,927
Marigold	9,927

Two-Can, Inc. charges each facility rent. As required, the rent has been adjusted
out and the depreciation on the building and the interest expense have been adjusted in.

CARLINVILLE ESTATES
EMERALD ESTATES
MARIGOLD ESTATES

PAGE 9, PART IX

MORTGAGE

The mortgage at Regions Bank is allocated as follows:

	Mortgage	Payment
Regions Bank--total	378,125	5,595
Allocation:		
Carlinville	126,042	1,865
Emerald	126,042	1,865
Marigold	126,042	1,865

MARIGOLD ESTATES

PAGE 14, PART XII, C

VEHICLE RENTAL

USE	Model Year and Make	Monthly Lease Payment	Rental Expense for Period
Resident Transportation	2003 Ford E 350	609	7,309
Administration	2001 Lexus	208	2,491
	TOTAL	817	9,800

PATTERSON HOUSE

VEHICLE LEASES--CENTRAL OFFICE

September 30, 2005

The company leases a vehicle which is used for care-related activities. The lease payments are paid by the central office and allocated 25 % to each facility.

2001 Lexus-used for facility business-Leased September, 2001.

The lease expense is as follows:

	2001 Lexus
Monthly Payment	830
# of Months	12
	9,960
	x 25%
Facility allocation	2,490

CARLINVILLE ESTATES
EMERALD ESTATES
MARIGOLD ESTATES
PATTERSON HOUSE

RENT

9/30/2005

The Central Office leases an office in Decatur, Illinois, from which all corporate business is transacted, records are stored, and the administrative staff operates. The rent in $650 per month, which is split $162.50 to each facility.

The landlord is not a related party.

PATTERSON HOUSE, INC.

OFFICERS COMPENSATION

September 30, 2005

	TOTAL COMP	CARLINVILLE ESTATES	EMERALD ESTATES	MARIGOLD ESTATES	PATTERSON HOUSE
Richard L. Grader	129,012	32,253	32,253	32,253	32,253
Daniel P. Caulkins	129,012	32,253	32,253	32,253	32,253
	258,024	64,506	64,506	64,506	64,506

MARIGOLD ESTATES

OWNER'S COMPENSATION

September 30, 2005

The owners' compensation included in the cost report is compensation for the following duties:

Richard L. Grader

- Purchasing
- Approving vendors
- Reviewing vendor invoices
- Paying invoices
- Reviewing public aid billings
- Reviewing accounts receivalbe
- Following up on billing disprepancies
- Managing cash flow
- Negotiating with bank
- Bookkeeping
- All financial management functions

Daniel P. Caulkins

- Operations of the facility
- Supervising employees
- Dealing with consultants
- Buying supplies
- Inspecting the facility
- Locating residents
- Dealing with resident families
- Dealing with government agencies

Both owners

- Dealing with local day program agency
- Attending employee meetings
- Recruiting employees
- Dealing with employee complaints
- Performing employee duties when the employee does not report to work

The above duties are not all encompassing. Like all small business owners, the owners work many hours on many different types of duties.